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IN THE

Supreme Court of the United States

October Term, 1983

No. —

GROUP HEALTH INCORPORATED,
Petitioner,

—v.—

MARGARET M. HECKLER, Secretary of Health and
Human Services, and PROVIDER REIMBURSEMENT
REVIEW BOARD,

Respondents.

**PETITION FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT**

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September 2, 1983

Questions Presented

1. Whether petitioner's constitutional rights under the First and Fifth Amendments have been violated by the respondent Secretary of Health and Human Services' ("Secretary") regulation providing favored treatment to religious orders.

2. Whether the principles of equitable estoppel and agency can be applied to prevent the Secretary from retroactively reversing a written 1974 ruling of its authorized agent, a Medicare Intermediary, after petitioner had already relied on that ruling to its detriment.

3. Whether the Secretary's blanket prohibition against reimbursement of interest on loans between related parties is invalid because its application produces results contrary to its own purpose and contrary to the purposes of the Medicare Act.

4. Whether the 1974 ruling of the Secretary's Medicare Intermediary to the effect that the Medicare principles of reimbursement would allow a reasonable return on the funds used by petitioner to purchase a hospital provider of Medicare services was a correct application of the Medicare statute and regulations.

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**PETITION FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT**

The petitioner Group Health Incorporated respectfully prays that a writ of certiorari issue to review the judgment of the United States Court of Appeals for the Second Circuit dated and entered in this proceeding on May 9, 1983.

Decisions Below

The unreported order of the Court of Appeals, unreported opinion of the District Court for the Southern District of New York and the decision of the Provider Reimbursement Review Board appear in the Appendix to this Petition.

Jurisdiction

This Court's jurisdiction is invoked under 28 U.S.C. § 1254(1). The judgment of the Court of Appeals for the Second Circuit was entered on May 9, 1983. An extension of time within which to file this petition was granted by Mr. Justice Marshall and this petition is timely filed in accordance with the extension.

Constitutional and Regulatory Provisions Involved

The First and Fifth Amendments to the United States Constitution and 42 C.F.R. § 405.419 (1982) appear in the Appendix to this Petition.

Statement of the Case

In 1974, petitioner Group Health Incorporated ("GHI") purchased Hillcrest General Hospital ("Hillcrest"), a general hospital providing an acute level of care. E.116.* Hillcrest was sold by GHI in February 1980. For the years 1974-1980 Hillcrest was an operating component of GHI. A.17-18;** E. 150.

Hillcrest provided medical services under the Medicare Program. The Medicare Program (Title XVIII of 42 U.S.C.) offers medical insurance to the elderly and is financed by the federal government.

Prior to its purchase by GHI, Hillcrest was a "proprietary" hospital owned by a partnership of doctors.

* The record before the Provider Reimbursement Review Board was submitted to the Court of Appeals as a separate exhibit. References to this record are denoted by "E" followed by the page number of the exhibit.

** References to the Joint Appendix are denoted by "A" followed by the page number of the Joint Appendix.

E.191, 262. As used in the Medicare Program, the term "proprietary" is used to distinguish an entity that expects the operation of the hospital to earn a profit for the owners, from an entity that may operate a hospital without any expectation of a return. 42 C.F.R. § 405.429 (b) (2) (1982).^{*} As a proprietary hospital, Hillcrest was entitled under the Medicare Program to reimbursement of a reasonable rate of return on its equity capital invested. *Id.* at § 405.429 (a).

GHI is a corporation organized under Article IXC of the New York State Insurance Law. A.24. It is a health service organization and issues health related insurance, e.g. medical, dental, etc. E.128. Article IXC corporations are a unique type of corporation existing only in New York State. E.171. An Article IXC corporation has no stockholders and it has no mutual policy holders. E.171. There is a statutory requirement of a surplus of a certain amount and that statutory surplus or reserve may not be invaded, with certain exceptions set forth in the statute. E.173; N.Y.S. Insurance Law § 256. In addition to the statutory reserve, certain funds are assigned to cover liabilities and potential liabilities. E. 172. Any monies of an Article IXC corporation that are not part of the statutory reserve, and are not assigned to liabilities are referred to as "subscriber funds." E.173. The New York State Insurance Department ("Insurance Department") closely regulates the operations of an Article IXC corporation. Ordinarily, under the supervision of the Insurance

^{*} Because the events in question took place in 1974, their reasonableness must be assessed by examining the conditions prevalent at that time, including the statutes and regulations then in effect. Since in most instances the wording of the regulations are the same today, for the convenience of the Court citations to the regulations in this Petition are to the 1982 Code of Federal Regulations. Statutory references will be treated similarly.

Department, GHI would invest its subscriber funds in a portfolio of investments. E.333, 201, 158-59, 224.

In 1972 and 1973, GHI considered the purchase of the proprietary Hillcrest Hospital. E.132, 461-62. GHI proposed to use its subscriber funds to purchase Hillcrest and it was necessary to obtain the approval of the Insurance Department before any agreement to purchase could be made. E.133, 461-62. The Insurance Department approved GHI's proposal to purchase Hillcrest Hospital, subject however to the condition that the subscriber funds used for the purchase earn a reasonable rate of return. E.464-65. Since the payments received for hospital services are made almost entirely by medical insurance programs, rather than by the patients themselves, the Insurance Department's condition required GHI to consult with the major third party payors, of which Medicare was one.

Under Part A of the Medicare Act, institutions providing hospital services to Medicare eligible persons are to be paid for the "reasonable costs" of providing those services. 42 U.S.C. § 1395f(b) (1982 Supp.). The "reasonable cost" of providing hospital services is "the cost actually incurred . . . and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included. . . ." 42 U.S.C. § 1395x(v)(1)(A) (1982 Supp.). In granting the Secretary authority to issue regulations establishing the items to be included, Congress expressly stated that the regulations should take into account both the direct and indirect costs of the provider and that the costs of providing services to Medicare patients should not be borne by the other patients. *Id.*

When the Medicare program was initiated in 1965, Congress determined that it would be beneficial to utilize the expertise already developed by private hospital insurance programs. S. Rep. No. 404, 89th Cong., 1st Sess., reprinted in 1965 U.S. Code Cong. & Ad. News 1992-95.

Accordingly, rather than set up a complete bureaucracy to administer the Medicare Program, Congress authorized the Secretary to administer the program through these private hospital care insurers. 42 U.S.C. § 1395h(a) (1982 Supp.).

Pursuant to 42 U.S.C. § 1395h(a), the Secretary enters into written contracts with private insurance companies to act as his agents, called "fiscal intermediaries", in administering the Medicare Program. Congress specifically authorized the Secretary to have such intermediaries determine amount of payments to be made to providers and "serve as a channel of communications from providers to the Secretary," provide consultive services to providers, and communicate to providers information and instructions furnished by the Secretary. 42 U.S.C. § 1395h(a). The regulations provide that the Secretary's "principles of reimbursement" "are to be applied by [the intermediaries]" in determining reasonable cost and in making payment of claims. 42 C.F.R. § 405.401(b), (c). The Secretary's regulations further provide that an "important role" of the fiscal intermediary is "to furnish consultive services to providers" in order to assure equitable payment under the Medicare Program. 42 C.F.R. § 405.401(e) (1982). Section 405.406(b) of 42 C.F.R. describes an intermediary as the Secretary's agent for the "interpretation and application of the principles of reimbursement."

Blue Cross/Blue Shield of Greater New York ("Blue Cross") is one such fiscal intermediary and was GHI's Medicare Intermediary ("Intermediary") with respect to Hillcrest Hospital. Since the Insurance Department required that there be a return upon any GHI subscriber funds that were used for the initial purchase of Hillcrest Hospital, GHI requested a ruling from its Medicare Intermediary as to whether such a return would be reimbursable under Medicare principles of reimbursement.

Because GHI was an Article IXC corporation, a unique form of business organization, the Intermediary was faced with a factual situation that was not directly addressed by the Medicare principles of reimbursement. E.122, 250. The principles of reimbursement addressed only two kinds of hospitals, proprietary hospitals, that is hospitals that continually operated for a profit or return on investment, and voluntary hospitals, that is not-for-profit charitable organizations that continually operated with no expectation of any return on investment. E.244. A hospital owned by an Article IXC corporation was unique and constituted a "third kind" of hospital to which the principles of reimbursement did not speak. E. 244. On the one hand, Hillcrest was to be converted by GHI to a hospital whose continued operation would be on a not-for-profit basis; on the other hand, the Insurance Department's condition for approval of the use of the subscriber funds clearly indicated that, with respect to the initial investment only, there was an expectation of a reasonable return. Accordingly, GHI was like a "proprietary" provider in that it expected a reasonable return on a single transaction, the purchase, but was like a "voluntary" or not-for-profit in that it did not expect a return on the day to day operations of the hospital.

While not addressing GHI's situation, the Secretary's regulations did provide general "principles of reimbursement" to be used as "guidelines" by fiscal intermediaries. 42 C.F.R. § 405.401 (1982). The Medicare Program also issued additional information in a Provider Reimbursement Manual. With respect to financing arrangements, the principles and guidelines provided that a return on equity capital was an allowable cost for proprietary organizations. 42 C.F.R. § 405.402(f) (1982). The guidelines also provided that interest on indebtedness was reimbursable for both proprietary and voluntary organizations. 42 C.F.R. § 405.419(a) (1982). However, where the indebtedness was incurred by an organization related to the

lender, the danger existed that a "sweetheart" deal with excessively high interest rates might be arranged. *Id.* at (c). Except in certain circumstances the guidelines stated that to be allowable for reimbursement purposes, interest expense must be established with non-related organizations. *Id.* at (b) (3) (ii), (c) (1). The regulations explained the rationale behind the related-party prohibition as follows:

Loans should be made under terms and conditions that a prudent borrower would make in an arm's-length transaction with lending institutions. The intent of this provision is to insure that loans are legitimate and needed and that the interest paid is reasonable.

42 C.F.R. § 405.419(c) (1) (1982).

However, in addition to setting forth a blanket prohibition against "loans" between related parties, the guidelines also provided several exceptions to this blanket prohibition. One of the several exceptions to the related-party prohibition concerns hospitals owned or operated by a religious order. 42 C.F.R. § 405.419 (c) (2) (1982). If a religious order operates a hospital and it advances monies to that hospital, a return on the advance is allowed for reimbursement purposes. In this situation, the investment by the order is treated as though the hospital were "borrowing" from the order. 42 C.F.R. § 405.419(c) (2) (1982). Of course, since the order also operates the hospital, there is no traditional "loan" as that term is commonly used. The "parties," the hospital and the order, are obviously "related," and may in fact be only one legal entity, and therefore one party.

Several other exceptions concern the situations in which a provider, including a non-profit provider, wishes to divert to the provision of patient care funds that previously have been invested on the providers behalf and

have been earning a return. In these situations, the provider presumably would not divert the funds to patient care unless it continued to receive a reasonable return on its investment. The guidelines treated these situations as through the provider were "borrowing" from itself and created exemptions where a provider "borrowed" its own "restricted" funds, whether "donor restricted" "funded depreciation" or "qualified pension plan." 42 C.F.R. § 405.419(c) (2). (1982).

Applying the rationale of the principles and guidelines to GHI's purchase of Hillcrest, the Intermediary ruled that a return on GHI's purchase of Hillcrest was allowable for reimbursement. The Intermediary found that the fact that the Insurance Department would not allow the surplus funds to be advanced for the purchase without a reasonable return was akin to the situation in which a provider "borrows" from a restricted fund. E.213,477. The entire proposed transaction, including the rate of return and the specific amounts that would be allowable for Medicare reimbursement purposes, had also been scrutinized in advance by the Intermediary and other regulatory authorities. The rate of return was reasonable (E.473), and this advance submission and approval supplied the "arms-length" and "bargaining" qualities that formed the underlying rationale of the general prohibition against reimbursing interest on loans between related parties. E.260-62.

Accordingly, by letter dated June 11, 1974, the Intermediary informed GHI that the use of the GHI subscriber funds to purchase Hillcrest Hospital would allow for a return under Medicare principles of reimbursement. E.473. In so ruling the Intermediary was fully aware that the return was primarily on investment that would be treated as a loan. As the Intermediary understood in 1974, the rationale underlying the exception for loans from restricted funds was to allow reimbursement of a reasonable return on funds invested in a hospital

by a provider, where the investment was a diversion to patient care of funds that had previously been used to earn a return for the provider, and that would not be so diverted if no return could be expected. In such cases, the provider reasonably expected a return on that particular transaction and was properly viewed as a "proprietary" provider with respect to the particular transaction.

Although the determination that the GHI return was allowable for Medicare purposes was considered at the highest level of the Intermediary's Management, the Intermediary did not, prior to issuing the ruling, consult the regional or national officials of the Department of Health Education and Welfare ("HEW").* E.219. Although the Intermediary was in continual contact with the HEW officials on various matters, the Intermediary did not consult with HEW officials concerning the allowability of the GHI return because it did not have sufficient doubt about the validity of its ruling that the return was allowable. E.219.

GHI relied upon the rulings by the Intermediary for Medicare with regard to its purchase of Hillcrest Hospital in 1974. If the Intermediary had ruled that the return was not allowable for Medicare reimbursement purposes, GHI would have either refrained from purchasing Hillcrest, or, if possible, would have attempted to obtain financing in such a manner that the true cost of that financing would be recognized or reimbursed for by borrowing the requisite funds from an institutional lender.

In New York State in the years in question costs incurred in providing patient care were reported to third-party payors each year in a Uniform Financial Report.

* HEW is now the Department of Health and Human Services.

In accordance with the Intermediary's written determination, on its cost report for each year from 1974 through 1980* GHI claimed the agreed upon amount as a return on its purchase of Hillcrest.

In 1979, Blue Cross, contrary to the approval it had previously given, formally disallowed any return for Medicare reimbursement purposes and then recouped from GHI all amounts previously paid to GHI that were attributable to the return. E.123, 400. Blue Cross apparently changed its position as a result of instructions from the Secretary. E.126, 311-12. The grounds for the instruction was the Secretary's view that GHI and Hillcrest were "related parties" under Medicare regulations, that the regulations prohibited reimbursement of interest on loans from related parties, and that GHI's situation did not come within any of the exceptions to this prohibition. E.397-98. The Secretary was apparently unaware of the Intermediary's rationale for allowing the return for Medicare reimbursement and at no time has the Intermediary's analysis of 1974 been addressed by the Secretary. The disallowance was made for all cost years then pending, 1974, 1975 and 1976. GHI then appealed the Intermediary's disallowance to the Medicare Provider Reimbursement Review Board ("Board").

The Board Decision

In a decision which the District Court later described as "somewhat unclear" (A.44), the Board decided that the Intermediary had properly disallowed the Return for reimbursement purposes. E.17. The Board's decision was based primarily on its view that the GHI funds used to

* The amounts claimed were as follows: 1974—\$458,028; 1975—\$526,957; 1976—\$528,600; 1977—\$527,155; 1978—\$527,155; 1979—\$527,155; 1980—\$86,657. Only the years 1974, 1975, and 1976 are involved in this case.

purchase Hillcrest Hospital were not restricted by a "donor," referring to the language of one of the several exceptions set forth in the regulations. E.16. Although reciting GHI's argument, the Board did not discuss the effect of the Intermediary having ruled in 1974 that the return was allowable, and the Board made no finding or conclusion with respect to the effect of the Intermediary's prior ruling.

The District Court Decision

Invoking federal jurisdiction pursuant to 42 U.S.C. § 1395oo and 28 U.S.C. § 1331, GHI appealed the Board's decision to the District Court. GHI moved for summary judgment and the Secretary cross-moved for summary judgment. The District Court granted the Secretary's motion. Although recognizing that the Board's rationale was unclear, the District Court stated that it could be inferred that the Board accepted the view that pursuant to 42 C.F.R. § 405.419(b)(3) interest is never reimbursable when paid to a lender related to the borrowing organization. A. 44.

Like the Board before it, the District Court failed to discuss the Intermediary's 1974 reasoning that the underlying rationale of the reimbursement guidelines, and the exceptions contained in section 405.419(c)(2), supported the initial determination that the GHI return was allowable. Despite the fact that GHI was not claiming that the case involved donor-restricted funds, the District Court merely stated that one exception, that for "donor restricted" funds did not literally apply (A. 47-49). The District Court then concluded that GHI's position "boils down to a claim of estoppel", an argument it rejected. A. 50-51.

The Second Circuit Decision

GHI appealed the District Court's decision to the Court of Appeals for the Second Circuit. In an Order

not intended for publication or citation as precedent the Second Circuit affirmed the District Court's decision. In its Order, the Second Circuit simply repeated the rationale used by the District Court, i.e., that the funds used by GHI to purchase Hillcrest were not restricted by a "donor" and therefore did not fit within the exact language of one of the exceptions allowing reimbursement of interest on loans between related parties. Like the District Court before it, the Court of Appeals failed to analyze the reasoning behind the Intermediary's 1974 ruling or the actual arguments raised by GHI. There is nothing in the Second Circuit's Order showing that the Intermediary's reasoning was incorrect. Rather the Court simply transformed the Intermediary's 1974 ruling into a ruling that the return was, in fact, a loan from donor-restricted funds and then announced what was already known, that the GHI facts did not literally fit that particular box.

With regard to GHI's argument that the Secretary was bound by the acts of his agent, the Intermediary, the Court, after first rejecting any contention that the Intermediary had the statutory authority to bind the Secretary, merely stated that,

[a]n intermediary's determination that a certain expense is reimbursable cannot "esto[p the Government] from insisting upon compliance with [a] valid regulation." *Schweiker v. Hansen*, 450 U.S. 785, 790 (1981) (per curiam).

The Court did not distinguish or discuss the case authority cited by GHI for the proposition that, on the facts of this case, the Government was bound by the written determination issued by its authorized agent, the Intermediary. Neither did the Second Circuit distinguish or discuss the Seventh Circuit decision, relied upon by GHI, that section 405.419 is not a valid regulation. Finally, the Court's decision made no reference whatsoever to GHI's argu-

ment that allowing a religious corporation to do what is prohibited to a non-religious corporation involves a clear constitutional violation of both the First and Fifth Amendments.

Reasons For Granting The Writ

1. The Secretary's Regulations Relied Upon In The Decision Below Raise Important Constitutional Issues Involving The Granting By The Government Of Favored Treatment To Religious Entities.

The Secretary's regulations contain a specific exception pertaining to "loans" made by a religious order to a hospital operated by its members. Section 405.419(c) (2) of 42 C.F.R. states that "if a provider operated by members of a religious order borrows from the order, interest paid to the order is an allowable cost." Accordingly, where a religious order advances monies to a hospital that it operates, a return paid on such an advance is recognized by the regulations as an allowable cost for Medicare purposes. This return is allowable despite the fact that the transaction is between related parties or may even be a transfer between departments or accounts of the same entity, and despite the fact that the transaction may be more akin to an investment than a traditional loan.* In disallowing the return claimed by GHI, the Secretary has denied GHI reimbursement that would be available to a religious order. This gross distinction between the rules facing religious and non-religious providers of medical services is a clear violation of the First Amendment and the equal protection guarantee incorporated into the Due Process clause of the Fifth Amendment.

* The religious order is, in effect, investing its own money in a hospital operated by its own members with the expectation of receiving a return on its investment.

It is now firmly established that the First Amendment's prohibition against laws "respecting an establishment of religion" demands "neutrality of treatment between religious and non-religious groups". *Committee for Public Education and Religious Liberty v. Nyquist*, 413 U.S. 756, 773, 792-93 (1973). A law or regulation may be one "respecting an establishment of religion" even though it does not promote a "state religion" and even though it does not aid one religion more than another but merely benefits all religions alike. *Id.* at 771; *Lemon v. Kurtzman*, 403 U.S. 602, 612 (1971).

Clearly the Secretary's regulation is not neutral. Where the provider's own funds are diverted from investment to patient care, the Secretary's regulations allow a religious provider the benefit of Medicare reimbursement while denying this reimbursement to secular providers such as GHI. The difference in treatment becomes especially glaring on the facts of this case. GHI was denied reimbursement despite the fact that it is undisputed that the nine-percent rate of return was reasonable, and that all the essential elements of the transaction were approved in advance, and in writing, by the Secretary's authorized agent. A religious provider would have been reimbursed without any advance approval and without the presence of the usual "bargaining" process that accompanies a loan or investment. Unless subsequently shown to be clearly excessive, the rate of return would be whatever rate had been unilaterally chosen by the religious order itself.

The creation of such special exemptions pertaining to religious organizations is not favored and is tolerated only in the most limited of circumstances. *King's Garden, Inc. v. F.C.C.*, 498 F.2d 51, 56-57 (D.C. Cir. 1974), *cert. denied*, 419 U.S. 996 (1974); *see Walz v. Tax Commission*, 397 U.S. 664 (1970) (historical tradition and non-entanglement considerations support limited tax exemption

for buildings and land used "exclusively for religious, educational or charitable purposes," and "not operating for profit"). However, with respect to a purely secular activity, the recent creation of an exemption limited solely to religious organizations clearly runs afoul of the Constitution. *Cf. King's Garden, Inc. v. F.C.C.*, *supra*, 498 F.2d at 56-57 (statutory exemption embracing religious organization engaged in secular broadcasting activity of doubtful constitutional validity). Here, there is no constitutional justification for treating religious and secular organizations differently with respect to the financing of hospital medical care and the amount of federal reimbursement provided.

Because of the discriminatory treatment of religious and secular providers established by the regulation, both the Court of Appeals for the Seventh Circuit and the United States Court of Claims have concluded that there is a serious constitutional question as to the validity of § 405.419(c). *Northwest Hospital, Inc. v. Hospital Service Corp.*, 687 F.2d 985 (7th Cir. 1982); *Trustees of Indiana University v. United States*, 618 F.2d 736 (Ct. Cl. 1980). Both Courts found that § 405.419(c) of the Medicare regulations affords special favored treatment to religious entities, and that the resulting discrepancy in reimbursement payments to secular providers and religious providers "would raise serious questions under the first amendment which generally prohibits the government from giving special favored treatment to a religious entity." *Northwest Hospital, Inc. v. Hospital Service Corp.*, *supra*, 618 F.2d at 740. Accordingly, both Courts have construed section 405.419 so as to avoid the constitutional question by interpreting the regulation so as to grant appropriate relief to secular providers. The Seventh Circuit held invalid in its entirety the Secretary's restriction with respect to transactions between related parties and the Court of Claims held the restriction invalid at least as applied to the situation of the secular provider before it.

By its judgment affirming the decision of the District Court, the Court of Appeals for the Second Circuit has placed itself squarely in conflict with the prior decisions of this Court interpreting the First Amendment to the Constitution. The Second Circuit judgment is also implicitly in conflict with the decisions and opinions of the Seventh Circuit and the Court of Claims. Both the Seventh Circuit and the Court of Claims viewed the constitutional issue raised here as presenting a very serious question as to the validity of the regulation and construed the regulation to avoid the constitutional question. Although raised prominently as a separate point in both GHI's main brief and its reply brief, and although urged again at oral argument, the Second Circuit did not even mention GHI's constitutional argument in its Order. Unless the Second Circuit neglected to consider the Point at all, it must be concluded that its view conflicted with that of the Seventh Circuit and the Court of Claims and that it considered the disparate treatment the regulations offer religious and secular providers to be constitutionally permissible. Yet, no explanation whatsoever was offered by the Second Circuit as to why this Court's decisions establishing the constitutional principle of neutrality between the religious and the secular are not offended by the disparate treatment provided by § 405.419(c).*

* The Secretary never defended the constitutionality of § 405.419(c). Rather, the Secretary suggested only that GHI did not have standing to raise the issue because, according to the Secretary, the only remedy for the Constitutional violation would be to strike down the exemption for the religious orders. This standing argument is entirely without merit and was unsupported by any authority. Moreover, the more appropriate remedy would clearly be to interpret the regulations to avoid a constitutional problem by extending to secular providers like GHI the benefit afforded religious orders. *E.g., Califano v. Westcott*, 443 U.S. 76, 89 (1979) ("extension rather than nullification is the proper course.")

In addition to being an unconstitutional violation of the First Amendment, the special treatment afforded religious providers is also a violation of the equal protection of the law guaranteed by the Fifth Amendment.

One effect of the special treatment afforded religious providers by § 405.419(c) is that with respect to the identical hospital services, other factors being equal, the Government will pay more to a provider operated by a religious order than to a provider operated by a secular non-profit organization. Also, any hospital operated by GHI must compete with hospitals operated by religious orders, and the special treatment afforded the religious orders places the Government in the position of favoring religious providers over secular providers. There is clearly no rational basis for such a distinction. As stated in *King's Garden, Inc. v. F.C.C.*, *supra*,

The criterion of discrimination—i.e., the religious or non-religious character of the owning and operating group—not only lacks a rational connection with any permissible legislative purpose, but is also inherently suspect. Such incidious discrimination violates the equal protection of the laws guaranteed by the Due Process Clause.

498 F.2d at 57.

From the above, it can be seen that it is important for this Court to grant certiorari in this case. As in *Committee for Public Education and Religious Liberty v. Nyquist*, *supra*, this case involves "an intertwining of societal and constitutional issues of the greatest importance." 413 U.S. at 759. The Medicare program is one of the most significant domestic programs of the United States and requires that the Government treat fairly in its reimbursement policies all types of providers, religious, secular, profit-making and not-for-profit. At the same time, the prohibition against laws respecting the establishment of religion and the guar-

antee of equal protection of the law lie at the very core of American democracy. Where serious questions arise regarding the application of these principles to a regulation that on its face expressly creates a special rule for religious orders, there is surely a need for the courts to carefully define what is permissible and impermissible. Especially in light of the Second Circuit's cavalier treatment of the precise issue found to be serious and important by the Seventh Circuit and the Court of Claims, the Supreme Court should grant certiorari in this case.

2. The Decision Below Raises Important And Recurring Questions Concerning Whether And In What Circumstances The Federal Government May Be Equitably Estopped Based On The Actions Of Its Agents, An Issue That Has Divided The Various Courts Of Appeals.

The issue of whether, and in what circumstances, the Federal Government may be equitably estopped has never been conclusively determined by the Supreme Court and has divided the various Courts of Appeals. The need for Supreme Court guidance on this issue is clear and has specifically been recognized by members of this Court.

[T]he question of when the Government may be equitably estopped has divided the distinguished panel of the Court of Appeals in this case [i.e. the Second Circuit], has received inconsistent treatment from other Courts of Appeals, and has been the subject of considerable ferment. [Citations omitted.].

Schweiker v. Hansen, 450 U.S. 785, 791 (1981) (Marshall, J. dissenting).

Moreover, a number of recent Courts of Appeals decisions have remarked on the uncertainty surrounding the entire issue of estoppel of the Federal Government

and the need for further guidance by the Supreme Court. See, e.g., *Community Health Services of Crawford County, Inc. v. Califano*, 698 F.2d 615 (3rd Cir. 1983), petition for cert. filed, *Margaret M. Heckler, et al. v. Community Health Services of Crawford County, Inc.*, No. 8356 ("*Community Health Services*"). There is presently a general conflict among the various Courts of Appeals as to the circumstances, if any, under which the Government can be estopped based on the actions of its agents. Accordingly, the instant case, in which GHI relied upon the written representations and agreements of an authorized Medicare Intermediary acting within the scope of its agency, presents a significant question of federal law which this Court should review and decide.

The issue presented here is important, not only in economic terms to the petitioner GHI, but in terms of the proper development of federal law with far reaching applications. The actions of the Government invade all aspects of life and bring it into daily contact with countless individuals and organizations. The Government, of course, can act only through its agents and those dealing with the Government must deal with its agents. In the present case, the Government contracted with Blue Cross to interpret the principles of reimbursement, determine the amount of reimbursement, and to act as a channel of communication between the Government and the providers. In dealing with the Government, it is important for the citizenry to know when it may rely upon information provided by Government agents and when it may not, and when it may rely upon written agreements entered into by Government agents and when it may not. For all of these reasons, the Supreme Court should take this occasion to clarify the question of when, if ever, the Government is bound by the acts of its agents.

In addition to squarely presenting this significant question of federal agency and estoppel law, an issue

which has divided the various Courts of Appeals, the judgment below is also in direct conflict with *Community Health Services, supra*, a decision of the Third Circuit Court of Appeals, on the specific issue of the role of the Medicare Intermediary and whether the Secretary, having held out the Intermediaries as its agent, is then bound by their actions.

In the instant case, the Second Circuit decided that the Government was not bound by the 1974 written agreement and representations of its own Medicare Intermediary. In so deciding, the Second Circuit relied solely upon this Court's summary reversal in *Schweiker v. Hansen*, 450 U.S. 785 (1981). However, *Hansen* merely held that there was a consistent line of cases holding that the Government will not be subject to estoppel where an eligible applicant has lost social security benefits because of possibly erroneous replies to oral inquiries. The facts in *Hansen* manifested that it was merely "another in that line of cases." 450 U.S. at 788.

Moreover, in rejecting the claim of estoppel, the Supreme Court specifically distinguished those cases in which the Government, as here, had entered into a written agreement supporting the claim of estoppel. 450 U.S. at 788, n.4; e.g., *United States v. Lazy F.C. Ranch*, 481 F.2d 985, 990 (9th Cir. 1973); *Walsonavich v. United States*, 335 F.2d 96, 100-01 (3rd Cir. 1964). Since *Schweiker v. Hansen* did not present the issue of reliance upon a written agreement, this Court took no position on the correctness of those Courts of Appeals decisions holding the Government estopped on the basis of the Government's written agreement. This case squarely presents the question left open in *Schweiker v. Hansen*, whether the Government will be bound by the acts of its authorized agents who have entered into a written agreement upon which the plaintiff has relied to its detriment.

Besides not being supported by *Schweiker v. Hansen*, the holding of the decision below on the issue of estoppel is in direct conflict with numerous Courts of Appeals decisions. *E.g. Community Health Services of Crawford County, Inc. v. Califano, supra; Johnson v. Williford*, 682 F.2d 868 (9th Cir. 1982); *Portman v. United States*, 674 F.2d 1155 (7th Cir. 1982); *Abkarin v. Immigration and Naturalization Service*, 669 F.2d 839 (1st Cir. 1982); *United States v. Lazy F.C. Ranch*, 481 F.2d 985 (9th Cir. 1973). Each of these cases held the Government estopped from relying upon a valid statute or regulation. The decision below is also seemingly in conflict with a number of Courts of Appeals decisions which have held that the Government can be estopped and have enunciated applicable criteria to determine whether in any particular instance estoppel is called for. *E.g., Home Savings & Loan Association v. Nimmo*, 695 F.2d 1251 (10th Cir. 1982); *Best v. Stetson*, 691 F.2d 42 (1st Cir. 1982); *Meister Bros., Inc. v. Macy*, 674 F.2d 1174 (7th Cir. 1982).*

The conflict among the various Courts of Appeals, and the need for Supreme Court resolution of this conflict by review of the instant case, is most evident by comparing

* While numerous Courts of Appeals have upheld the principle of estoppel against the Government, the actual test to be applied to determine whether in a particular instance the Government should be estopped varies from circuit to circuit. Some cases rely upon the test for estoppel used against private parties. *Home Savings & Loan Association v. Nimmo, supra; Portmann v. United States, supra*. Others rely primarily upon whether the action of the Government's agent can be considered affirmative misconduct. *Community Health Services of Crawford County, Inc. v. Califano, supra; Akbarin v. Immigration and Naturalization Service, supra*. Still others rely upon general equity considerations. *Johnson v. Williford, supra; United States v. Lazy F.C. Ranch, supra*. Still others follow more individual tests. *Best v. Stetson, supra; Meister Bros., Inc. v. Macy, supra*.

the Second Circuit's decision here to that of the Third Circuit in *Community Health Services, supra*.

In both cases, a provider of Medicare services approached the Secretary's agent, the Intermediary, and requested a ruling upon a reimbursement question. In both cases the Intermediary provided a ruling without consulting the Secretary, a ruling upon which the provider relied to its detriment. In both cases, acting several years after the event, the Secretary disavowed the ruling provided by its agent and sought to recoup funds paid to the provider pursuant to the Intermediary's ruling. After a full discussion, the Third Circuit held that the Secretary was estopped from repudiating the acts of its agent, the Medicare Intermediary. In contrast, in an Order not intended for publication or citation as precedent, the Second Circuit held that the Intermediary did not have the authority to bind the Secretary and that an Intermediary's determination cannot estop the Government. Order, p. 5-6.

In addition to diverging in result, the Second and Third Circuits are also in direct conflict concerning the important statutory and regulatory question of the role and purpose of the Intermediary in the Medicare program. In a full discussion of the role of the Intermediary in the Medicare program, the Third Circuit correctly observed that the statutory and regulatory scheme of the Medicare program required that the provider present its request for a ruling to the Intermediary.

The administrative structure established under Medicare made it quite difficult for the [provider] to get an answer to [its reimbursement] question. The administrative process precluded [the provider] from presenting an inquiry directly to the Secretary. Rather, it was required to consult a fiscal intermediary appointed by the Secretary to serve as his agent. . . . The intermediary was required statutorily to relay information and in-

structions from the Secretary to providers and to serve as a channel of communications from providers to the Secretary.

698 F.2d at 618. In light of the statutory and regulatory scheme, the Third Circuit held that the provider had acted properly and in good faith in presenting the inquiry to the Intermediary and that the Intermediary's action in failing to consult the Secretary constituted affirmatively misconduct sufficient to estop the Secretary. 698 F.2d at 620, 622-24.*

In contrast, the Second Circuit took no heed of the statutory and regulatory scheme. Instead it simply decreed without discussion or explanation that "it is inconceivable that GHI did not think to consult the Secretary." Order, p. 5. In so doing, the Second Circuit simply ignored the several statutory and regulatory provisions that require the Intermediary to: (1) "serve as a channel of communication from providers to the Secretary" (42 U.S.C. § 1395h[a]); (2) "be an important source of consultive assistance to providers" and "be available to deal with questions and problems on a day-to-day basis" (42 C.F.R. § 405.406[b]); and (3) interpret and apply the principles of reimbursement to providers on behalf of the Medicare program. 42 C.F.R. § 405.401 (c), (e); § 405.406(b).

As the Third Circuit recognized, and the Second Circuit ignored, in consulting the Intermediary on questions of the application of reimbursement principles, the provider is acting in accordance with the Medicare ad-

* The same affirmative misconduct is present in this case and the District Court opinion below suggests a motive for the Intermediary's failure to consult the Secretary. The Intermediary was not representing the Secretary's interests and was acting "in large part from the perspective of a competitor seeking ways to achieve the agreed upon results for itself." A.52.

ministrative process and is consulting "the *only* governmental source of information available to it." 698 F.2d at 626 (emphasis in original); *see also* 698 F.2d at 625.

To impose liability on [the provider] for its good faith compliance with Medicare procedures and to allow the government to escape liability created by its agent's violation of those procedures would, in effect, repudiate the Medicare administrative process that was established by Congress.

Community Health Services, supra, 698 F.2d at 624. It is clear that any other conclusion would not only be unfair and unjust but would drastically alter the Medicare Administrative scheme. Since one would never know the Intermediary had consulted the Secretary and was speaking for the Secretary, the risk of dealing with the Intermediaries would be so great that providers would be forced to abandon the Intermediaries, contrary to Congress' intent.* *See* 698 F.2d at 623.

In sum, this Court should grant certiorari in this case because it presents an important application of federal agency and estoppel law, which has divided the various Courts of Appeals and as to which the Courts of Appeals, and members of this Court, have recognized the need for Supreme Court guidance. The conflict, and the need for guidance, is dramatically manifested in the instant case in that the decision of the Second Circuit conflicts with decisions of other Circuits with respect to the circumstances in which estoppel is available against the Government and, more specifically, with respect to the availability of estoppel against the Government based upon the written representations and affirmative misconduct of a Medicare fiscal intermediary.

* The Government has petitioned for certiorari in *Community Health Services* and therefore presumably agrees that the issues that are raised by both the instant case and *Community Health Services* warrant Supreme Court review.

Finally, it is quite plain from a mere recitation of the facts in this case that GHI has been treated unfairly. It is also submitted that the Second Circuit has given GHI's arguments short shrift and has reached an erroneous conclusion. Accordingly, in addition to all other reasons, justice would be served by the granting of certiorari in this case.

3. The Decision Below Conflicts With The Decisions Of Other Courts Of Appeals As To The Validity Of The Regulation Relied Upon By The Secretary To Disallow The Claimed Reimbursement.

Section 405.419(c) of 42 C.F.R. prohibits the reimbursement of interest expense on loans between related entities. This regulation was the primary ground upon which the Secretary disallowed GHI's present claim for reimbursement. The Second Circuit also relied heavily upon it in upholding the disallowance. GHI has argued throughout that § 405.419(c) is invalid as being contrary to the purposes of the Medicare Act. In support of this proposition GHI relied, *inter alia*, upon *Northwest Hospital Inc. v. Hospital Service Corp.*, 687 F.2d 985 (7th Cir. 1982).

In *Northwest Hospital, Inc. v. Hospital Service Corp.*, *supra*, the Seventh Circuit held that "the blanket disallowance of related-party interest expense contained in § 405.419(c) is broader than either the language or the purpose of the Medicare statute can be construed to authorize." 687 F.2d at 992. The Court in *Northwest Hospital* held that the allowability of reimbursement on interest, even between related parties, should be determined through the general regulatory criteria for "necessary" and "proper" interest contained in 42 C.F.R. § 405.419(b) (2) and (3). 687 F.2d at 992. Thus, where there is no challenge to the need for the financing or the reasonableness of the interest rate, reimbursement

under the Medicare Act will be proper, whether or not the interest is paid to a related party.*

In the decision below the Court of Appeals did not even respond to GHI's argument that § 405.419(c) was invalid. However, by relying upon this section the Court of necessity upheld its validity and brought itself squarely in conflict with the Seventh Circuit's *Northwest Hospital* decision.** The Ninth Circuit has also apparently upheld the validity of § 405.419(c) in *Goleta Valley Community Hospital v. Schweiker*, 647 F.2d 894 (9th Cir. 1981). The Seventh Circuit acknowledged *Goleta Valley* in its *Northwest Hospital* decision but described it as a cursory discussion and declined to follow it.

The conflict among the Circuit Courts as to the validity of 42 C.F.R. § 405.419(c) is an additional ground for this Court to grant petitioner's petition for certiorari.

* *South Boston General Hospital v. Blue Cross of Virginia*, 409 F.Supp. 1380 (W.D. Va. 1976) also stands for the proposition that this section is invalid. The case of *Trustees of Indiana University v. United States*, 618 F.2d 736 (Ct. Cl. 1980) while not specifically holding the regulation invalid, implies that this is the case by upholding reimbursement of interest on a loan between related parties.

** At the oral argument below, the Second Circuit demonstrated by its questions that it realized that a decision upholding the validity of this section would bring it squarely in conflict with the holding on the Seventh Circuit in *Northwest Hospital*.

CONCLUSION

For these reasons, a writ of certiorari should issue to review the Order of the Second Circuit.

Respectfully submitted,

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September 2, 1983

APPENDIX

Order

**UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT**

At a Stated Term of the United States Court of Appeals, in and for the Second Circuit, held at the United States Court House, in the City of New York, on the 9 day of May one thousand nine hundred and eighty-three.
Present:

HON. JAMES L. OAKES,
HON. RICHARD J. CARDAMONE,
HON. RALPH K. WINTER,
Circuit Judges.

82-6134

GROUP HEALTH INCORPORATED,

Appellant,

—v.—

RICHARD S. SCHWEIKER, Secretary of Health and Human Services, and PROVIDER REIMBURSEMENT REVIEW BOARD,
Appellees.

Group Health Incorporated (GHI) appeals from a decision of the United States District Court for the Southern District of New York, Robert L. Carter, Judge, granting summary judgment for the appellees and upholding an administrative determination that GHI was not entitled to reimbursement for imputed interest claimed as an expense under the Medicare Act, 42 U.S.C. § 1395 (1976). We hold that the expenditure is not reimbursable because, since it was made by GHI to its

N.B. Since this statement does not constitute a formal opinion of this court and is not uniformly available to all parties, it shall not be reported, cited or otherwise used in unrelated cases before this or any other court.

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own Hillcrest Hospital division, it cannot be characterized as a "loan" under applicable regulations. We therefore affirm Judge Carter's decision.

GHI is a nonprofit corporation chartered under N.Y. Ins. Law § 250 (McKinney 1966 & Supp. 1981-82) for the purpose of providing health-related insurance services. Under New York law, GHI's use of surplus funds is subject to regulation by the New York State Insurance Department. In 1974, GHI sought to purchase a hospital facility, Hillcrest, and the purchase was approved by the Insurance Department on the condition that GHI be reimbursed under the Medicare program an amount equaling a reasonable rate of return on the funds used to purchase Hillcrest. GHI did not consult with Medicare program officials (Secretary) to determine whether reimbursement was appropriate but instead relied upon the opinion of Blue Cross-Blue Shield of Greater New York that the purchase of Hillcrest could be construed as a "loan" between GHI and Hillcrest, and that "interest" expenses could be reimbursed under an exception to 42 C.F.R. § 405.419(1981) which generally provides that in transactions involving related parties, interest is not a reimbursable expense. GHI of course concedes that, as the owner of Hillcrest, it is "related" to the hospital.

When Blue Cross later denied reimbursement after a routine audit, GHI appealed to the Provider Reimbursement Review Board pursuant to 42 U.S.C. § 1395oo. The Board decided *inter alia* that GHI's expenditure for Hillcrest was not a loan from a "donor-restricted fund," 42 C.F.R. § 405.423(b)(2), and therefore not within that specific exception to the general rule that interest expenses arising from transactions between related parties cannot be reimbursed. 42 C.F.R. § 405.419(c)(1). GHI and Blue Cross originally reasoned that be-

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cause GHI's funds were subject to state agency approval, they were "restricted" within the meaning of the statute. The Review Board rejected this improbable construction noting that the regulatory supervision exercised by the New York Insurance Department was wholly different from the statutory definition of restricted funds as funds "which must be used only for the specific purpose designated by the donor." 42 C.F.R. § 405.423(b)(2).

Board decisions are subject to the standard of review applicable to most administrative determinations; as long as the Board did not act arbitrarily or capriciously and there is substantial evidence to support its position, the decision will stand. See 42 U.S.C. § 1395oo(f)(1); *Bowman Transportation, Inc. v. Arkansas-Best Freight System, Inc.*, 419 U.S. 281, 285 (1974). We have no difficulty upholding Judge Carter's decision that the Board's conclusion that the funds used to purchase Hillcrest were not "donor-restricted" was supported by substantial evidence. As the phrase itself suggests, donor-restricted funds are funds earmarked for specific purposes; because such funds are functionally separate from and not fungible with a provider's general funds, the Secretary has determined that interest paid on such funds may be reimbursed notwithstanding the general rule regarding interest arising out of transactions between related parties. Even if we were to assume that this transaction could be properly characterized as a loan—a characterization we find questionable—we have no doubt that it was not a loan from donor-restricted funds. This exception to the general rule that interest expense is not reimbursable applies only in those cases where the use of funds has been limited to a particular purpose. The Insurance Department's regulation of GHI's use of surplus funds is obviously not such a restriction. GHI's argument would transform transactions which are in fact investments into "loans" leaving

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the federal government to guarantee nonprofit health providers a reasonable rate of return of their investment. Common sense as well as the statutory scheme suggests that GHI's position is untenable. See 42 C.F.R. § 405.429(a)(1), (2) (distinguishing between for-profit and non-profit providers, allowing reimbursement for return on equity capital of for-profit providers).

GHI argues at length that the Government should be bound by the earlier Blue Cross determination. Although it is true that the Act provides that private entities such as Blue Cross can serve as fiscal intermediaries, 42 U.S.C. § 1395h, they do not have the authority to bind the Secretary, who retains the authority to pass on what constitutes a "reasonable" expense for reimbursement purposes. See 42 U.S.C. § 1395(v)(1)(A); 42 C.F.R. § 405.1885(b). Thus we reject the contention that Blue Cross had any statutory authority to bind the Secretary, its capacity was advisory only. An intermediary's determination that a certain expense is reimbursable cannot "esto[p the Government] from insisting upon compliance with [a] valid regulation." *Schweiker v. Hansen*, 450 U.S. 785, 790 (1981) (per curiam). Nor do we find GHI's arguments as to the equities of its predicament persuasive; given the strained approach relied on to conclude that these were donor-restricted funds, it is inconceivable that GHI did not think to consult the Secretary.

Judgment affirmed.

/s/ JAMES L. OAKES
/s/ RICHARD J. CARDAMONE
/s/ RALPH K. WINTER
Circuit Judges.

Opinion

**UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK**

80 Civ. 6163 (RLC)

[Date of Entry: March 23, 1982]

GROUP HEALTH INCORPORATED,

Plaintiff,

—against—

**RICHARD S. SCHWEIKER, Secretary DEPARTMENT OF
HEALTH AND HUMAN SERVICES, and PROVIDER RE-
IMBURSEMENT REVIEW BOARD,**

Defendants.

APPEARANCES

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Opinion

CARTER, District Judge

Group Health Incorporated ("GHI") seeks judicial review of a final decision of the Provider Reimbursement Review Board ("Board") holding certain interest expenses not reimbursable under the federal Medicare program, 42 U.S.C. § 1395, *et seq.* Jurisdiction to review the Board's ruling is conferred by 42 U.S.C. § 1395oo (f) (1). The reimbursement claim has generated cross-motions for summary judgment.

FACTUAL BACKGROUND

In February 1974, GHI purchased Hillcrest General Hospital ("Hillcrest") for \$5,791,000 from a partnership of physicians. Hillcrest became an operating component of GHI, not a separate legal entity. The transaction was structured so as to assure the approval of the New York State Insurance Department, the New York State Health Department and Blue Cross-Blue Shield of Greater New York ("Blue Cross"). Inasmuch as GHI is a non-profit health services and health insurance organization, its activities are regulated by the state agencies overseeing insurance and health. The Insurance Department would not permit GHI to spend its subscriber funds unless it arranged to receive a certain return on the investment.

Blue Cross was GHI's fiscal intermediary in the Medicare program. As such, it was responsible for reviewing claims and administering governmental payment as agent for the Secretary of Health and Human Services ("HHS"). As a competitor in the health insurance field, Blue Cross also represented its own interest in creating mechanisms for insurer purchases of private hospitals. The Insurance Department agreed to approve the purchase if Blue Cross would include in its prospective Medicare reimbursement rates a 9 per cent return on equity invested by GHI. Blue Cross and the state agencies con-

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cluded that by construing the funds used to purchase Hillcrest as a "loan from restricted funds," interest from Hillcrest to GHI would be reimbursable. As communicated to GHI, the terms of this agreement included a "[s]tandard annual repayment of \$579,600" from Hillcrest to GHI. Transcript of Board Hearing at 0473.

Based on a series of letters setting forth the positions of Blue Cross and the Insurance Department, GHI/Hillcrest included accrued interest expenses in Medicare cost reports filed for fiscal 1974, 1975 and 1976. A Blue Cross field audit in 1977 revealed that payments had not been made with respect to the 1974 and 1975 interest due. That discovery prompted the intermediary to ask the Regional Medicare Director to review the situation. On September 29, 1978, the Regional Medicare Director advised Blue Cross that no reimbursements were due GHI. The transaction was an investment, not a loan, according to this report. Moreover, interest is never reimbursable when paid to a lender related to the borrowing organization. 42 C.F.R. § 405.419(3). Blue Cross reacted by disallowing the interest claimed.

The Board sustained the adjustment to reimbursement ordered by the intermediary. Its rationale is somewhat unclear because, after presenting the parties' contentions, the decision merely rejects two of plaintiff's arguments without expressly adopting any specific Blue Cross position. It can be inferred, however, that the Board accepted the Regional Medicare Director's view regarding Hillcrest's interest expense.

There is no dispute over the propriety of Hillcrest's use of the accrual basis of accounting to report interest expense incurred but not liquidated during a given fiscal year. It was not unlawful for Hillcrest to wait until 1979 to make payment of the moneys owed GHI. The Board found, however, that no substantive payments were

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made in 1979. Each cash transfer from Hillcrest to GHI was preceded by a slightly larger transfer in the opposite direction, purportedly reimbursing Hillcrest for past losses. These "classic 'Peter-to-Paul-to-Peter,'" transactions, Board Hearing Decision at 6, were not considered payments by the Board, and the Board refused to accept them as products of arms-length dealing.

Apparently, non-payment of the interest was important to the Board (and the Blue Cross auditor) for two reasons. First, it indicated that the entire financial arrangement was an investment, as apposed to a loan, involving related parties seeking to serve their own best interests. To the extent that Blue Cross' original reimbursement approval anticipated actual rather than accrued payments, the 1979 transfers also demonstrated GHI's failure to observe that condition. In this regard, the Board noted that "GHI's subscriber funds were never increased by a return for the use of such fund." Board Hearing Decision at 6. Thus, GHI never satisfied the condition most essential to the Insurance Department's initial agreement to approve the Hillcrest purchase.

The Board also concluded that the funds used to purchase Hillcrest were not restricted within the meaning of 42 C.F.R. § 405.419(b)(a)(ii), (c) and, therefore, were not excepted from that section's prohibition of interest costs incurred between related parties. Statutes and regulations requiring Insurance Department consent to the investment of subscriber funds could not be confused with restrictions on their use. A not-for-profit insurance corporation can use such funds in many ways consistent with applicable regulations. The fiction created by Blue Cross and the state agencies regarding the classification of this transaction could not overcome the evidence that an investment in fact occurred.

Finally, the Board held *The Trustees of Indiana University v. United States*, 618 F.2d 736 (Ct. Cl. 1980)

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distinguishable from the instant case. No elaboration of distinguishing features was given other than an extraction of the circumstances found unusual by the Court of Claims. Among those unique factors was the nonprofit hospital's affiliation with a State university from which it borrowed money at less than current interest rates and its lack of State funding or access to outside sources of capital. *Id.* at 740.

SCOPE OF REVIEW

Review of the Board's decisions is limited in nature. Reimbursement determinations supported by substantial evidence must be affirmed. *American Hospital Management Corp. v. Harris*, 638 F.2d 1208, 1211 (9th Cir. 1981). Substantial evidence is that which adequately supports the conclusions drawn. *Medical Center of Independence v. Harris*, 628 F.2d 1113, 1117 (8th Cir. 1980). The Board's disallowance may be overturned only if it was arbitrary, capricious, an abuse of discretion, or unsupported by law or substantial evidence. 42 U.S.C. § 1395oo(f)(1); 5 U.S.C. § 706(2)(A), (E).

Challenges to the propriety of regulations enacted by the Secretary also face a significant burden. Regulations promulgated pursuant to the Medicare statute are valid if reasonably based in fact even though they fail to achieve their objective with mathematical precision. *American Hospital Management Corp.*, *supra* at 1212-3; *Fairfax Hospital Association, Inc. v. Califano*, 585 F.2d 602, 606 (4th Cir. 1978). Furthermore, an administrative agency's interpretation of its regulations merits considerable deference. *Medical Center of Independence*, *supra* at 1117.

DETERMINATION

Much of plaintiff's attack on the Board's reasoning is inapposite. GHI's lengthy treatment of the accrual

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method of recording expenses and the irrelevance of actual payment to the statutory scheme indicates a misinterpretation of the Board's discussion of these issues. Without questioning the propriety of GHI's accounting practices, the Board held that there was no underlying reimbursable interest expense. That determination was based on findings that GHI's purchase of Hillcrest was not a loan from restricted funds, that the transaction was between related parties and that GHI failed to satisfy the conditions of Blue Cross' initial approval of the deal. The Board's conclusion that payment never was made only served to reinforce those findings.

Plaintiff does not contest the fact that GHI and Hillcrest were related entities. It attempts instead label [sic] the Board's interpretation of 42 C.F.R. §405.419 arbitrary and capricious insofar as it failed to carve out an exception for the particular transaction involved here. Two courts have ignored the seemingly absolute prohibition of transfers between related parties that are not from restricted funds.

South Boston General Hospital v. Blue Cross of Virginia, 409 F. Supp. 1380 (W.D. Va. 1976) is the only case holding that all interest expenses between related parties must be scrutinized individually to discover if they pose the potential dangers set forth in 42 C.F.R. § 405.419(c). *Id.* at 1385. Failure to interpret the regulation as such, the court ruled, would frustrate rather than further the statutory intent to reimburse expenses necessary to the delivery of efficient health care services. *Id.* No other court has adopted the *South Boston* approach. The Court of Claims has, however, interpreted the regulation so as to harmonize with the objectives of the statute it implements and has exempted a unique transaction from its scope. *The Trustees of Indiana University*, *supra* at 739-40. The relationship between

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Indiana University, the lender, and Indiana University Hospitals, the related borrower, did not present the evils against which the regulation is directed—relationships in which the lender “may unduly influence the hospital’s decision to the prejudice of the government if the latter reimburses the hospital for the interest payments.” *Id.* at 739. These parties differed from other related entities because the University did not own the hospitals and had limited control thereof, the hospitals could not obtain funds from any other source and the interest charged was far below market rates. *Id.* at 740.

Assuming that some attention to individual fact situations must be paid by the Board in determining whether a related party interest transaction should be treated as required by the regulations, the decision in this case satisfies that standard. The Board thoroughly investigated the relationship between GHI and Hillcrest and determined that it was not analogous to that involved in *Indiana University*. Sufficient evidence exists to support this conclusion. See *Jackson Park Hospital Foundation v. United States*, 659 F.2d 132, 137-8 (Ct. Cl. 1981) (restricting *Indiana University* to its very unique facts). GHI owned and controlled Hillcrest and was not prevented from seeking other funding sources. The manner in which the “loan” was liquidated indicated that GHI was not complying with the original Blue Cross and Insurance Department conditions of approval and that the transaction might have been constructed so as to prejudice the government by having it reimburse expenses not contemplated by the Medicare statute. One witness testified that no one involved in the pre-purchase negotiations believed that the transaction was a loan. Transcript of Board Hearing at 0174-5. Plaintiff’s contention that the Board took a dogmatic approach to the regulatory language is contradicted by both the hearing transcript and

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the formal decision. The evidence, which will not be reviewed in detail here, is sufficient to support the Board's conclusion that no reimburseable interest expense accrued.

GHI's position boils down to a claim of estoppel. Plaintiff would have the Board's determination overruled merely because it parted from the intermediary's initial impression that the transaction was arms-length and reimbursement should be forthcoming. The Board and the court would be bound by analyses performed by entities which did not represent, in full, the government's interests. While the estoppel argument is separated from the abuse of discretion discussion in plaintiff's papers, the notion of holding the Board and the government to the arrangements made by Blue Cross, GHI and the Insurance and Health Departments pervade the entire presentation to the court.

Estoppel in favor of GHI would undermine the reimbursement procedures established by the Medicare statute. Congress mandated a system in which providers receive interim estimated payments based on current costs as determined by the provider and its intermediary. 42 U.S.C. § 1395g; 42 C.F.R. §§ 405.401; 405.402; 405.454. A crucial element of this advanced funding system is the reservation to the Secretary of the power to adjust retroactively the amount of reimbursement to counteract previously made overpayments. 42 U.S.C. § 1395x(v)(1)(A); 42 C.F.R. §§ 405.454(f), 405.1885; *Appalachian Regional Hospitals, Inc. v. United States*, 576 F.2d 858, 866 (Ct. Cl. 1978); see *Wilson Clinic & Hospital, Inc. v. Blue Cross of South Carolina*, 494 F.2d 50, 52 (4th Cir. 1974). It is indisputable that the United States can always retrieve monies mistakenly outlaid. *Wilson Clinic & Hospital, Inc.*, *supra* at 52. There is no justification, therefore, for preventing the government from withholding payments mistakenly authorized, especially when recoupment is built

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into a statutory scheme. Where the intermediary advises the provider in large part from the perspective of a competitor seeking ways to achieve the agreed upon results for itself, and where the government is not consulted on a borderline question of interpretation, precluding retroactive adjustments would threaten the integrity of the Medicare system. It is illogical to bind the Board to determinations made in anticipation of the transaction when subsequent events indicated that the premises for those determinations were unfounded.

As a general matter, courts have refused to estop the government as a result of mistaken advice given by its agents or employees. See *Rock v. United States*, 279 F. Supp. 96, 101 (S.D.N.Y. 1968) (Levet, J.). The Supreme Court has indicated that, short of affirmative misconduct, actions by government representatives will not estop the government from "insisting upon compliance with valid regulations." *Schweiker v. Hansen*, — U.S. —, 101 S. Ct. 1468, 1470-1 (1981). Reluctance to estop the government is particularly acute when the public fisc is threatened by estoppel. *Id.* at 1471 & n.4. In light of a regulatory scheme dependent upon reevaluation of prior reimbursements, these general misgivings must be respected in the instant case.

For the reasons set forth above, plaintiff's motion for summary judgment is denied and defendant's motion for summary judgment is granted.

IT IS SO ORDERED.

Dated: New York, New York.
March 22, 1982

/s/ ROBERT L. CARTER
U.S.D.J.

**Provider Reimbursement Review Board
Hearing Decision**

80-D-77

Date of Hearing—June 10, 1980

[Date of Decision: September 19, 1980]

Cost Reporting Periods Ending December 31, 1974, 1975
and 1976

Case No. 79-122

**PROVIDER—Hillcrest General Hospital, Flushing,
New York**

Provider No. 33-0379

VS

**INTERMEDIARY—Blue Cross Association, Blue Cross/Blue
Shield of Greater New York**

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*Provider Reimbursement Review Board Hearing Decision***ISSUE:**

Whether or not the Intermediary's disallowance of interest expense is correct?

STATEMENT OF FACTS:

Hillcrest General Hospital is a 246-bed, non-profit, acute care hospital. It filed its Medicare cost reports for the fiscal years ending December 31, 1974, 1975, and 1976 with its fiscal intermediary Blue Cross/Blue Shield of Greater New York.

In February 1974, Group Health Incorporated (GHI) purchased Hillcrest Hospital from a partnership of physicians and it became an operating component of GHI. Hillcrest is neither a separate legal entity nor a wholly-owned subsidiary. Inasmuch as GHI is a non-profit health services corporation organized pursuant to Article IX-C of the Insurance Law of New York, its activities are closely regulated by the New York State Department of Insurance. Accordingly, in 1973 application to purchase Hillcrest was made to the Insurance Department by GHI. On February 15, 1974, the State Department of Insurance approved the purchase of Hillcrest Hospital by GHI subject to the following terms:

1. The purchase price to be \$5,791,000;
2. The Associated Hospital Service of New York (Blue Cross) would permit to be included in its "prospective reimbursement rates" a return on equity invested by GHI in an amount equal to the average annual income earned by an Article IX-C Corporation on its portfolio; and
3. Certification by the Department of Health to be obtained.

Subsequently, on March 26, 1974, the Assistant Commissioner of Health Economics of New York advised Associ-

Provider Reimbursement Review Board Hearing Decision

ated Hospital Service (Blue Cross) in a letter that the funds used by GHI to purchase Hillcrest Hospital "... would be construed as a loan from restricted funds." This same letter stated:

"Under the AHS formula, Title XVIII formula interest paid on loans from restricted funds is an allowable cost. Therefore in establishing reimbursement rates for the hospital purchased by GHI, it is anticipated that the major third party payors will include their proportionate shares of interest paid to GHI subject to any specific third party formula limitations as to reasonableness and amount."

Then, on June 11, 1974, Blue Cross advised GHI:

"Accordingly, the mortgage terms are acceptable to us for Medicare and Blue Cross reimbursement.

Once again the Assistant Commissioner of Health Economics in a letter dated August 26, 1974, clarified the position of the Department of Health with respect to Hillcrest Hospital.

"Discussions concerning the situation at Hillcrest were held between the Health Department and the Insurance Department and we reached the joint conclusion that in this case the funds used by GHI in the purchase would be construed as a loan from restricted funds. The Division of Health Economics considers interest paid on loans from restricted funds to be an allowable cost. Thus, such interest will be included in the reimbursement rate."

Based on the foregoing advise the Provided in filing its cost reports for periods ending December 31, 1974, 1975 and 1976 included in its allowable costs interest on the subscriber funds of GHI used to purchase Hillcrest Hospital.

Provider Reimbursement Review Board Hearing Decision

1974	\$458.028 [sic]
1975	526,957
1976	528,600

during the field audit of the 1975 cost report in June, 1974 cost report in May, 1976, an accrual of interest expense as cited above was noted but no determination was made as to whether the interest was actually paid. Then, during the field audit of the 1975 cost report in June, 1977, it was discovered that payments had not been made with respect to the 1974 and 1975 interest deduction up to and including the date of the field audit. After discussions with the Provider, Blue Cross acting on behalf of Hillcrest asked the Regional Medicare Director of Bureau of Health Insurance, HCFA, on November 11, 1977, to review the situation. Finally, on September 29, 1978, the Regional Medicare Director advised Blue Cross to the following:

"Regarding the reimbursement issue of the "loan" transaction, we are of the opinion that no loan was ever made. The funds involved were used by GHI to purchase a facility, not for operating purposes, and the accounting transaction is carried on GHI's books as an investment. Therefore, the theory of the "loan" cannot possibly be reimbursed, as the hospital maintains, as a borrowing from restricted funds. Since GHI is not a proprietary organization, it is not entitled to a return on equity. Moreover, one of the prime elements required for interest to be "proper" is that the interest be paid to a lender not related through control, ownership or personal relationship to the borrowing organization. The failure of interest payments is merely additional evidence that the hospital and GHI are operating at their mutual benefit and not at arms-length. Accordingly, for all of the above reasons,

Provider Reimbursement Review Board Hearing Decision

we believe that the "loan" is a nonreimbursable cost.

Accordingly, the Intermediary disallowed the interest claimed by Hillcrest on its cost reports for 1974, 1975, and 1976 with respect to the subscriber funds used by GHI to purchase Hillcrest. The Provider has taken exception to this disallowance.

Provider argues that in preparing its cost reports for the periods under appeal it relied on the representations in the correspondence of the State of New York Insurance and Health Department in 1974. The Health Department in its letter of August 26, 1974, stated in part:

"... the funds used by GHI in the purchase would be construed as a loan from restricted funds."

As such, argues the Provider, interest paid to a restricted fund is an allowable cost pursuant to HIM-15-1, Section 224.1. As an Article IX-C Corporation, GHI's investment in a hospital required the approval of the Superintendent of Insurance of the State of New York. Further, the Provider argues that the accrual of the subject interest for reimbursement purposes is proper. Both the Regulation 42 CFR 405.453(b)(2) and Administrative Policy HIM-15-1, Section 202.1 clearly indicate that an accrual is a proper and acceptable method of recording interest. In fact, the accrual method of accounting is required for purposes of Medicare cost reporting. Prior to April 1, 1978, no policy existed that required the payment of an accrued liability within a specified time period (HIM-15-1, Section 2305). Inasmuch as Medicare promulgated a new rule for cost reporting periods beginning after April 1, 1978, with respect to the liquidation of liabilities, Hillcrest complied with the new rule by making payments in 1979 for the accrued interest, part of which is the subject of this appeal.

Provider Reimbursement Review Board Hearing Decision

The Provider further argues that its case is sufficiently similar to that of *The Trustees of Indiana University (Indiana University Hospitals) v. U.S.*, U.S. Court of Claims, No. 71-78, CCH30,398. Accordingly, the Board is urged to adopt the reasoning of the Court of Claims which allowed interest between related parties. In the *Indiana* case, the hospitals were part of the State university system and were not separate legal entities. The Court in its decision stated:

"As noted earlier, the regulation has an explicit exception for interest paid to a religious order by a provider operated by members of the order. Denying reimbursement of interest payments by a nonprofit hospital to its affiliated university while permitting reimbursement of payments to an affiliated religious order would raise serious questions under the first amendment which generally prohibits the government from giving special favored treatment to a religious entity."

The Intermediary argues that there was a lack of arms-length dealing between GHI and Hillcrest in the loan transaction. The disallowance of the interest in question was based on advice from the Regional Office.

"Moreover, one of the prime elements required for interest to be "proper" is that the interest be paid to a lender not related through control, ownership or personal relationship to the borrowing organization. The failure of interest payments is merely additional evidence that the hospital and GHI are operating at their mutual benefit and not at arms-length." (Letter from Regional Office dated September 29, 1978)

The record clearly shows that during the periods in question interest payments were not made by Hillcrest to GHI. In fact payments were not made until 1979. It is im-

Provider Reimbursement Review Board Hearing Decision

portant to note that these payments were preceded by cash transfers from GHI to Hillcrest.

Cash Transfers from GHI to Hillcrest

August 30, 1979	\$1,430,883	Reimbursement for 1974, 1975 and 1976 losses
November 15, 1975 [sic]		Reimbursement for 1977
	1,651,555	1978 losses

Cash Transfers from Hillcrest to GHI

August 31, 1979	\$1,384,419	1974 and 1975 Interest and Other Changes
November 21, 1979	1,582,910	1976, 1977 and 1978 In- terest

Citation of Applicable Law, Regulations, and Program Instructions

- I. *Regulations 42 CFR 405, Regulations No. 5, Subpart D*
 1. Section 405.419 Interest Expense
 2. Section 405.427 Cost to Related Organization
- II. *Program Instruction*
 1. HIM-15-1, Chapter 2 Interest Expense

Conclusions and Findings

The Provider Reimbursement Review Board, after consideration of the facts, the parties' contentions, and evidence presented concludes and finds that the Provider is not entitled to include in reimbursable cost the accrued interest costs between itself and GHI.

The Board does not dispute that cost reports are to be filed on the accrual basis of accounting as was done in the instant case. However, the Board takes issue with two arguments fostered by the Provider, namely, liquida-

Provider Reimbursement Review Board Hearing Decision

tion of the liability and borrowing from a restricted fund. In the instant case, the Provider has demonstrated that in form it liquidated its liability to GHI on August 31, 1979, and November 21, 1979. However, the board finds that in substance these liquidations were not made in an arms-length transaction. As illustrated by the Intermediary, the transactions between GHI and Hillcrest in August and November, 1979, are classic "Peter-to-Paul-to-Peter" transactions. Had GHI and Hillcrest been dealing at arms-length, funds used to pay the alleged interest would have been generated from operations instead of intercompany accounts. The Provider argues that inasmuch as GHI's subscriber funds were being used to purchase Hillcrest, the State of New York required GHI to earn a return on these funds equal to what the subscriber funds were earning on other investments. The accrual of the interest expense on the books of Hillcrest with a contra income account being credited on GHI's books when looked at with exchanging checks for similar amounts in August and November, 1979 to liquidate the liability in question does not in substance demonstrate that Hillcrest and GHI acted at arms-length. In substance, GHI's subscriber funds were never increased by a return for the use of such fund.

The other question posed to the Board involves the issue as to whether or not restricted funds were used to purchase Hillcrest. The record does not support a holding that GHI's subscriber funds are restricted within the meaning of 42 CFR 405.419(c)(2). The subscriber funds are not donor restricted funds within the meaning of 42 CFR 405.423(b)(3).

"Donor restricted funds must be used only for the specific purpose designated by the donor."

Basically, subscriber funds are characterized as the difference between the assets and liabilities of a corporation.

Provider Reimbursement Review Board Hearing Decision

Subscriber funds are not restricted for a specific purpose, but rather can be used within the parameters of New York State Insurance Laws. In the instant case, GHI purchased Hillcrest Hospital pursuant to Section 260 of the Insurance Law. Section 260 allows an Article IX-C Corporation to invest in a hospital provided such purchase is approved by the Superintendent of Insurance. Accordingly, it is difficult to rationalize that the subscriber funds used to purchase Hillcrest were restricted where in fact State law does not restrict such a purchase. Approval should not be confused with restriction.

Last, the Board notes that the instant case differs in many ways from that heard by the Court of Claims, *The Trustees of Indiana University v. U.S.* In its decision the Court of Claims cautioned:

"We hold only that in the particular and unusual circumstances of this case—where the nonprofit hospital is affiliated with a State university, the State appropriates no money for the hospital, the hospital is prohibited by State law from borrowing from outside sources, and the university lends the hospital essential funds at less than the current rate of interest—the prohibition in the regulation against reimbursement of interest paid to a related organization is inapplicable.

Provider Reimbursement Review Board Hearing Decision

DECISION:

The adjustment of the Intermediary is sustained. The provider is not entitled to interest on subscriber funds of GHI used to purchase the facility.

Board Members Participating

Thomas M. Tierney

H. Joseph Curl

Carolyn B. Lewis

James Houdek, Jr., CPA

FOR THE BOARD

/s/ THOMAS M. TIERNEY
THOMAS M. TIERNEY
Chairman

September 19, 1980

Constitutional and Regulatory Provisions Involved

FIRST AMENDMENT

Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the Government for a redress of grievances.

FIFTH AMENDMENT

No person shall be held to answer for a capital, or otherwise infamous crime, unless on a presentment or indictment of a Grand Jury, except in cases arising in the land or naval forces, or in the Militia, when in actual service in time of War or public danger; nor shall any person be subject for the same offence to be twice put in jeopardy of life or limb; nor shall be compelled in any criminal case to be a witness against himself, nor be deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation.

42 C.F.R. § 405.419

§ 405.419 Interest Expense

(a) Principle. Necessary and proper interest on both current and capital indebtedness is an allowable cost. However, interest cost incurred as a result of judicial review by a Federal court (as described in § 405.454(1)) is not an allowable cost.

Definitions—(1) Interest. Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. This is usually for such purposes as working capital for normal operating expenses. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes, such as acquisition of facilities and equipment, and capital

Constitutional and Regulatory Provisions Involved

improvements. Generally, loans for capital purposes are long-term loans.

(2) Necessary. Necessary requires that the interest:

(i) Be incurred on a loan made to satisfy a financial need of the provider. Loans which result in excess funds or investments would not be considered necessary.

(ii) Be incurred on a loan made for a purpose reasonably related to patient care.

(iii) Be reduced by investment income except where such income is from gifts and grants, whether restricted or unrestricted, and which are held separate and not commingled with other funds. Income from funded depreciation or provider's qualified pension fund is not used to reduce interest expense. Interest received as a result of judicial review by a Federal court (as described in § 405.454(1)) is not used to reduce interest expense.

(3) Proper. Proper requires that interest:

(i) Be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made.

(ii) Be paid to a lender not related through control or ownership, or personal relationship to the borrowing organization. However, interest is allowable if paid on loans from the provider's donor-restricted funds, the funded depreciation account, or provider's qualified pension fund.

(c) Borrower-lender relationship. (1) To be allowable, interest expense must be incurred on indebtedness established with lenders or lending organizations not related through control, ownership, or personal relationship to the borrower. Presence of any of these factors could affect the "bargaining" process this [sic] usually accompanies the making of a loan, and could thus be suggestive

Constitutional and Regulatory Provisions Involved

of an agreement on higher rates of interest or of unnecessary loans. Loans should be made under terms and conditions that a prudent borrower would make in arms-length transactions with lending institutions. The intent of this provision is to assure that loans are legitimate and needed, and that the interest rate is reasonable. Thus, interest paid by the provider to partners, stockholders, or related organizations of the provider would not be allowable. Where the owner uses his own funds in a business, it is reasonable to treat the funds as invested funds or capital, rather than borrowed funds. Therefore, where interest on loans by partners, stockholders, or related organizations is disallowed as a cost solely because of the relationship factor, the principal of such loans shall be treated as invested funds in the computation of the provider's equity capital under § 405.429.

(2) Exceptions to the general rule regarding interest on loans from controlled sources of funds are made in the following circumstances. Interest on loans to providers by partners, stockholders, or related organizations made prior to July 1, 1966, is allowable as cost, provided that the terms and conditions of payment of such loans have been maintained in effect without modification subsequent to July 1, 1966. Where the general fund of a provider "borrows" from a donor-restricted fund and pays interest to the restricted fund, this interest expense is an allowable cost. The same treatment is accorded interest paid by the general fund on money "borrowed" from the funded depreciation account of the provider or from the provider's qualified pension fund. In addition, if a provider operated by members of a religious order borrows from the order, interest paid to the order is an allowable cost.

(3) Where funded depreciation is used for purposes other than improvement, replacement, or expansion of facilities or equipment related to patient care, allowable

Constitutional and Regulatory Provisions Involved

interest expense is reduced to adjust for offsets not made in prior years for earnings on funded depreciation. A similar treatment will be accorded deposits in the provider's qualified pension fund where such deposits are used for other than the purpose for which the fund was established.

(d) Loans not reasonably related to patient care.

(1) The following types of loans are not considered to be a purpose reasonably related to patient care:

(i) For loans made to finance acquisition of a facility, that portion of the cost that exceeds:

(A) Historical cost as determined under § 405.415

(b); or

(B) The cost basis determined under § 405.415

(g); and

(ii) Loans made to finance capital stock acquisitions, mergers, or consolidations for which revaluation of assets is not allowed under § 405.415(1).

(2) In determining whether a loan was made for the purpose of acquiring a facility, we will apply any owner's investment or funds first to the tangible assets, then to the intangible assets other than goodwill and lastly to the goodwill. If the owner's investment or funds are not sufficient to cover the cost allowed for tangible assets, we will apply funds borrowed to finance the acquisition to the portion of the allowed cost of the tangible assets not covered by the owner's investment, then to the intangible assets other than goodwill, and lastly to the goodwill.

(e) Limitation on Federal participation for capital expenditures. See § 405.485. "Nonallowable costs related to certain capital expenditures" for situations where interest on borrowed funds is not an allowable cost.